NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Draft Service Definitions
6/12/03

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NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

COMMUNITY SUPPORT – ADULTS

Service Definition and Required Components

Community Support services consist of mental health and substance abuse rehabilitation services and supports necessary to assist the person in achieving rehabilitative, sobriety and recovery goals. The service is designed to meet the educational, vocational, residential, mental health/substance abuse treatment, financial, social and other treatment support needs of the recipient. The service activities of Community Support consist of a variety of interventions: identification and intervention to address barriers that impede the development of skills necessary for independent functioning in the community; development and revision of the recipient's Person Centered Plan (PCP); and one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to home, school and work environments; therapeutic mentoring; symptom monitoring and self management of symptoms. Community Support includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Community Support workers also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services. Community Support includes facilitated peer support focused on relapse prevention for substance abusers who have completed a structured substance abuse treatment program.

The Community Support worker must consult with identified providers, include their input into the service planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. The provider assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

Provider Requirements

Community Support services must be delivered by practitioners employed by a mental health/substance abuse provider organization which meets standards established by the Division of MHDDSAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by either being certified by the Local Management Entity or by being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Community Support may be provided by only one organization. This organization is identified in the Person Centered Plan and is responsible for obtaining authorization from the LME for the PCP. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, street locations, etc.

Organizations which provide Community Support services must have an on-call capability which can direct consumers to appropriate crisis intervention services.

Staffing Requirements

Persons who meet the requirements specified for Qualified Professional or Associate Professional status according to 10 NCAC may deliver Community Support. Qualified Professionals are responsible for developing, and coordinating the Person Centered Plan (PCP). Paraprofessionals may deliver Community Support services to provide case management services and assist the consumer to develop critical daily living and coping skills.

All Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10 NCAC 14V and according to licensure requirements of the appropriate discipline.

Paraprofessional level-providers who meet the requirements specified for Paraprofessional status according to 10 NCAC 14V may deliver Community Support services within the requirements of the staff definition specific in the above role. When a paraprofessional provides Community Support services, a QP is responsible for overseeing the development of the consumer's person centered plan. When a paraprofessional provides Community Support services that Paraprofessional must be under the supervision of a QP. Supervision of Paraprofessionals is also to be carried out according to 10 NCAC 14V. A Certified Clinical Supervisor (CCS) and Certified Clinical Addiction Specialist (CCAS) may deliver Community Support. A Substance Abuse Counselor Intern and a Substance Abuse Peer Specialist may also deliver Community Support under supervision.

Service Type/Setting

Community Support is a direct and indirect periodic service where the Community Support worker provides direct intervention and also arranges, coordinators, and monitors services on behalf of the recipient. This service is provided in any location. Community Support services may be provided to an individual or a group of individuals.

Community Support services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. Community Support activities include person-centered planning meetings and meetings for treatment/service plan development.

This service is billable to Medicaid.

Program Requirements

All individuals receiving Community Support must receive a minimum of two (2) contacts per month ,with (1) one contact occurring face-to-face with the recipient. Sixty Per Cent (60%) or more of Community Support services which are delivered must be performed face-to-face with recipients and Sixty Per Cent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers. The portion of services is measured in total units over that which were provided during the timeframes set forth in the plan. Units are billed in fifteen (15) minute increments. Community Support services may be provided to groups of individuals.

Caseload size for a Community Support worker may not exceed 1:30 (one Community Support worker per thirty [30] clients). When Community Support services are provided in a group, groups may not exceed eight (8) individuals.

Utilization Management

Referral and Authorization by Local Management Entity is required. For Medicaid reimbursement, the services must be included in an individual's Person Centered Plan, and authorized prior to or on the day services are to be provided. Initial authorization for services would not exceed a six (6) month period. A maximum of thirty-two (32) units of Community Support services can be provided in a 24-hour period. No more than 1280 units of services can be provided to an individual in a three (3) month period.

Entrance Criteria

The recipient is eligible for this service when:

A There are two (2) identified needs in the appropriate documented domains,

AND

B There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability

AND/OR

C Level of Care Criteria, level 1,2, or 3A/ASAM (American Society for Addiction Medicine)

AND

D The recipient is experiencing difficulties in at least one of the following areas:
1. Is at risk for institutionalization, or hospitalization or is placed outside the natural living environment.
2. Is receiving or needs crisis intervention services or intensive in home services
3. Has unmet identified needs from multiple agencies.
4. Needs advocacy and service coordination to direct service provisions from multiple agencies.
5. DSS has substantiated abuse, neglect, or has established dependency.
6. Presenting with intense, verbal and limited physical aggression due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.
7. Functional problems which may result in the recipient's inability to access clinic-based services in a timely or helpful manner

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.
E. Recipient is regressing; the service plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 180 days and is so documented in the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A. Recipient has achieved goals and is no longer eligible for Community Support services.
B. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
C. Recipient/family no longer wishes to receive Community Support services.
D. Recipient has achieved one (1) year of abstinence from substances.

**Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.*

Expected Outcomes

This service includes interventions that address the functional problems associated with complex and/or complicated conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increased coping skills and achievement of the highest level of functioning in the community. The focus of the interventions include: minimizing the negative effects of psychiatric symptoms which interfere with the recipient's daily living, financial management and personal development; developing strategies and supportive interventions for avoiding out-of-home placements for adults; supporting ongoing

treatment assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's disability and coordinating rehabilitation services in the PCP.

Documentation Requirements

Minimum standard is a daily full service note that includes the purpose of contact, describes the provider's interventions, includes the time spent performing the interventions and documenting the effectiveness of the interventions.

Service Exclusions

An individual can receive Community Support services from only one provider organization at a time.

Community Support services can be billed for individuals living in other residential facilities in which they are receiving 'watchful oversight', e.g. supported housing.

For persons residing in higher level residential programs (e.g. PRTF, Group Living Moderate and High), Community Support services are limited to individuals transitioning from or to these residential programs. Community Support and residential services can be billed for a maximum of two consecutive weeks per each admission or discharge from a residential facility.

Group Community Support can not be billed on the same day as psychosocial rehabilitation

Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

COMMUNITY SUPPORT – CHILDREN/ADOLESCENTS

Service Definition and Required Components

Community Support services are services and supports necessary to assist the youth 18 years old or younger and their caregivers in achieving developmental, rehabilitative and recovery goals. Community Support services are psychoeducational and supportive in nature and intended to meet the mental health or substance abuse needs of children and adolescents with significant functional deficits, or who because of negative environmental, medical or biological factors, are at risk of developing or increasing the magnitude of such functional deficits. Included among this latter group are those at risk for significant developmental delays, atypical development, substance abuse, or serious emotional disturbance (SED) which could result in an inability to live successfully in the community without services and guidance.

The service activities of Community Support consist of a variety of interventions: education and training of caregivers and others who have a legitimate role in addressing the needs identified in the service plan as well as preventive; developmental, and therapeutic interventions designed for direct individual activities; assist with skill enhancement or acquisition, and support ongoing treatment and functional gains; development of the consumer's Person Center Plan (PCP), and one-on-one interventions with the consumer to develop interpersonal and community relational skills, including adaptation to home, school, work and other natural environments; therapeutic mentoring; and symptom monitoring and self management of symptoms.

Provider Requirements

Community Support services must be delivered by practitioners employed by a mental health/substance abuse provider organization which meets standards established by the Division of MHDDSAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrated that they meet these standards by either being certified by the Local Management Entity or by being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Community Support providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, street locations, etc.

Organizations which provide Community Support services must have an on-call capability which can direct children/adolescents and/or their families to appropriate crisis intervention services.

Staffing Requirements

Persons who meet the requirements specified for Qualified Professional or Associate Professional status according to 10 NCAC 14V, or the N.C. Infant-Toddler Program Guidance for Personnel Certification (APSM 120-1) may deliver Community Support within the requirements of the staff definition specified in the above rule. Supervision is provided according to supervision requirements specified in 10 NCAC 14V and according to licensure requirements of the appropriate discipline.

Paraprofessional level-Providers who meet the requirements specified for Paraprofessional status according to 10 NCAC 14V or the N.C. Infant-Toddler Program Guidance for Personnel Certification (APSM 120-1) may deliver Community Support services within the requirements of the staff definition specific in the above role. When a paraprofessional provides Community Supports services, a QP is responsible for overseeing the development of the consumer's person centered plan. When a paraprofessional provides Community Support services they

must be under the supervision of a QP. Supervision of Paraprofessionals is also to be carried out according to 10 NCAC 14V.

Service Type/Setting

Community Support is a direct and indirect periodic service where the Community Support worker provides direct intervention and also arranges, coordinators, and monitors services on behalf of the recipient. This service is provided in any location. Community Support services may be provided to an individual or a group of individuals.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. Community Support activities include person-centered planning meetings and meetings for treatment/service plan development.

This service is billable to Medicaid.

Program Requirements

All youth receiving Community Support must receive a minimum of two (2) contacts per month with one (1) contact occurring face-to-face with the recipient.

Sixty Per Cent (60%) or more of Community Support services which are delivered must be performed face-to-face with recipients and Sixty Per Cent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers. The portion of services will be measured in total units over that were provided during the timeframes set forth in the plan. Units will be billed in fifteen (15) minute increments. Community Support services may also be provided to groups of individuals.

Caseload size for a Community Support worker may not exceed 1:30 (One Community Support worker per thirty [30] clients). When Community Support services are provided in a group, groups may not exceed eight (8) individuals.

Utilization Management

Referral and Authorization by Local Management Entity is required. For Medicaid reimbursement, the services must be included in an individual's Person Centered Plan, and authorized on the day services are to be provided. Initial authorization for services would not exceed a six month period. A maximum of thirty-two (32) units of Community Support services can be provided in a 24-hour period. No more than 1280 units of Community Support services can be provided to an individual in a six (6) month period.

Entrance Criteria

The recipient is eligible for this service when:

A There are two (2) identified needs in the appropriate documented domains,

AND

B There is an Axis I or II diagnosis present, other than a diagnosis of primary Developmental Disability.

AND/OR

C Level of Care Criteria, level 1,2, or 3 A/ASAM (American Society for Addiction Medicine)

AND

D The recipient is experiencing difficulties in at least one of the following areas:

1. Is at risk for institutionalization, or hospitalization or is placed outside the natural living environment.
2. Is receiving or needs crisis intervention services or intensive in home services.
3. Has unmet identified needs from multiple agencies.

4. Needs advocacy and service coordination to direct service provisions from multiple agencies.
5. DSS has substantiated abuse, neglect, or has established dependency.
6. Presenting with intense, verbal and limited physical aggression due to symptoms associated with diagnosis, which aggression is sufficient to create functional problems in the home, community, school, job, etc.
7. Functional problems which may result in the recipient's inability to access clinic-based services in a timely or helpful manner.
8. Is in active recovery from Substance Abuse dependency and is in need of continuing relapse prevention support.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A Recipient has achieved initial service plan goals and additional goals are indicated.
B Recipient is making satisfactory progress toward meeting goals.
C Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D Recipient is not making progress; the service plan must be modified to identify more effective interventions.
E Recipient is regressing; the service plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted at a minimum of 180 days and is so documented in the Person-Centered Plan and service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A Recipient has achieved goals and is no longer eligible for Community Support services.
B Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
C Recipient/family no longer wants Community Support services.
D Recipient has achieved one (1) year of abstinence from substances.

**Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.*

Expected Outcomes

This service includes interventions that address the functional problems associated with complex and/or complicated conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increased coping skills and achievement of the highest level of functioning in the community. For substance abusers, the expected outcomes include the achievement of abstinence from substances. The focus of the interventions include: minimizing the negative effects of psychiatric and substance abuse symptoms which interfere with the recipient's daily living, financial management and personal development; developing strategies and supportive interventions for avoiding out-of-home placements; supporting ongoing treatment assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's disability and coordinating rehabilitation services in the Person Centered Plan.

Documentation Requirements

Minimum standard is a daily full service note that includes the purpose of contact, describes the provider's interventions; the time spent performing the intervention and documenting the effectiveness of the interventions.

Service Exclusions

An individual can receive Community Support services from only one provider organization at a time.

Community Support services can be billed for individuals living in other residential facilities in which they are receiving 'watchful oversight', e.g. supported housing. For persons residing in higher level residential programs (e.g. PRTF, Group Living Moderate and High), Community Support services are limited to individuals transitioning from or to these residential programs. Community Support and residential services can be billed for a maximum of two consecutive calendar weeks per each admission or discharge from a residential facility. Community Support can not be billed on the same day as Intensive In-Home Services (IHS) or Multi-Systemic Therapy (MST).

Group Community Support can not be billed on the same day as Day Treatment (DT), Partial Hospitalization (PH) or Substance Abuse Intensive Outpatient Program (SAIOP).

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Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

CRISIS MANAGEMENT

Service Definition and Required Components

Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions and crisis prevention activities. Crisis Management services are available at all times, 24/365. Crisis response provides an immediate evaluation, triage and access to acute MH/DD/SA services, treatment and supports, to effect symptom reduction, harm reduction, and/or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports/services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability and appropriate response.

Crisis management also includes crisis prevention and supports which are designed to reduce the incidence of recurring crises. These supports and services should be specified in a recipient's Crisis Plan.

Provider Requirements

Crisis management services must be delivered by a team of practitioners employed by a mental health/substance abuse provider organization which meets standards established by the Division of MHDDSAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrated that they meet these standards by either being certified by the Local Management Entity or by being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Staffing Requirements

Crisis Management services must be provided by a team of individuals that includes a Qualified Professional according to 10 NCAC 14V and must be either a Psychiatric Nurse or a Licensed Clinician with credentials in a behavioral/medical profession. One of the team members must be a Certified Addictions Counselor (CAC). Adequate psychiatric backup provided by a board certified or eligible psychiatrist must be available to the team. A QP or AP with experience in Developmental Disabilities must be available to the team as well. Paraprofessionals with competency in crisis management may also be a member of the crisis management team. Paraprofessionals with competency in crisis management who meet the requirements in 10 NCAC 14V may be members of a team when supervised by the Qualified Professional. A Certified Clinical Supervisor (CCS) and a Certified Clinical addiction Specialist (CCAS) may deliver Community Support. Substance Abuse Counselor Intern and Substance Abuse Peer Specialists may also deliver Crisis Management support under supervision.

All practitioners must demonstrate competencies in crisis response and crisis prevention. Professional staff must have appropriate licenses, training and experience and non-licensed staff must have appropriate training and experience.

Service Type/Setting

Crisis Management is a direct and periodic service that is available at all times, 24/365. It is a 'second level' service, in that other services should be billed before Crisis Management, as appropriate and if there is a choice. For example, if the recipient's outpatient clinician stabilized his/her crisis, the Outpatient billing code should be used, not crisis management. This service is Medicaid billable.

Crisis Management may be provided in any location. Teams providing this service must provide at least 80% of their units on a face to face basis. This will be measured annually for all services provided to Medicaid

individuals who receive this service. Units will be billed in fifteen (15) minute increments. If a face to face assessment is required, this assessment must be delivered in the least restrictive environment and provided in or as close as possible to a person's home, in the individual's natural setting, school, work, local emergency room, etc. This response must be mobile. . The result of this assessment should identify the appropriate crisis stabilization intervention.

Program Requirements

Crisis Management services should be delivered in the least restrictive environment and provided in or as close as possible to a person's home.

Crisis Management services must be capable of addressing all psychiatric, substance abuse and developmental disability crises for all ages to help restore (at a minimum) an individual to their previous level of functioning.

Crisis Management services may be delivered by one (1) or more individual practitioners on the team.

For recipients new to the public system, Crisis Management must develop a Crisis Plan before discharge. This Crisis Plan should be provided to the individual, caregivers (if appropriate) and any agencies which may provide ongoing treatment and supports after the crisis has been stabilized For recipients who are already receiving services, Crisis Management should recommend revisions to existing crisis plans, as appropriate.

Utilization Management

For individuals who are not enrolled with a Local Management Entity (LME), there is no prior authorization required. Prior authorization is required for individuals who are enrolled with the LME. Crisis Management should be used to divert individuals from Inpatient psychiatric and detoxification services. These services are not used as a "step down" services from Inpatient hospitalization.

Entrance Criteria

The recipient is eligible for this service when:

A. The person and/or family is experiencing an acute, immediate crisis as determined by a crisis rating scale.
B. The person and/or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis
C. The person and/or family members evidences impairment of judgment and/or impulse control and/or cognitive/perceptual disabilities
D. The person is intoxicated or in withdrawal and in need of substance abuse treatment and unable to access services without immediate assistance

Priority should be given to individuals with a history of multiple crisis episodes and/or who are at substantial risk of future crises.

Continued Stay Criteria

The recipient's crisis has not been resolved or their crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or crisis respite home.

Discharge Criteria

Recipient's crisis has been stabilized and his/her need for ongoing treatment/supports has been assessed. If the recipient has continuing treatment/support needs, a linkage to ongoing treatment or supports has been made.

Expected Outcomes

This service includes a broad array of crisis prevention and intervention strategies which assist the recipient in managing, stabilizing or minimizing clinical crisis or situations. This service is designed to rapidly assess crisis situations and a recipient's clinical condition, to triage the severity of the crisis, and to provide immediate, focused crisis intervention services which are mobilized based on the type and severity of crisis.

Documentation Requirements

Minimum standard is a daily log which includes a description of staff intervention; the time spent performing the intervention, and the outcome of the intervention.

Service Exclusions

Assertive Community Treatment, Intensive In-Home Services, Multisystemic Therapy, and Medical Community Substance Abuse (SA) Residential Treatment, Non-Medical Community SA Residential Treatment, Detoxification Services, Inpatient SA Treatment except for the day of admission. Crisis Management services may be provided to an individual who receives inpatient psychiatric services on the same day of service.

Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

DIAGNOSTIC ASSESSMENT

Service Definition and Required Components

A Diagnostic/Assessment is an intensive clinical and functional evaluation of a consumer's mental health or substance abuse condition that results in the issuance of a Diagnostic Assessment report with recommendations for service delivery that provides the basis for the development of a Person Centered Plan (PCP).
The Diagnostic/Assessment must include the following elements:

A. A chronological behavioral health (mental health and substance abuse) history of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
B. Biological, psychological, familial, social and environmental dimensions and identified strengths and weaknesses in each area;
C. A description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms and recent progressions;
D. A strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
E. Diagnoses on all five (5) axes of DSM-IV;
F. Review of the recipient's alcohol and substance abuse history and presenting problems;
G. Evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
H. A recommendation regarding target population eligibility and eligibility; and
I. Evidence of recipient participation including families or when applicable guardians or other caregivers. For substance abuse focused Diagnostic/Assessment, the provider must also use the Diagnostic Tool specified by the Division of MHDDSAS appropriate to the person being served (e.g., SUDDS IV, ASI, SASSI).

Provider Requirements

Diagnostic/Assessments must be conducted by practitioners employed by a mental health/substance abuse provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrated that they meet these standards by either being certified by the Local Management Entity (LME) or by being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Diagnostic/Assessment services are not provided directly by the LME.

Staffing Requirements

The Diagnostic/Assessment team must include at least two (2) Qualified Professionals (QP), according to 10 NCAC 14V, both of whom are licensed clinicians; one of the team members must be a qualified practitioner whose professional licensure or certification authorizes the practitioner to diagnose mental illnesses and/or addictive disorders. A psychiatrist shall review all psychiatric and medical functional areas in a consumer's Diagnostic/Assessment. For substance abuse focused Diagnostic/Assessment the team must include a CCS, CCAS or CSAC.

Service Type/Setting

Diagnostic/Assessment is a direct periodic service which can be provided in any location. This service is Medicaid billable.

Program Requirements

An initial Diagnostic/Assessment shall be performed by a Diagnostic/Assessment team for each recipient being considered for receipt of services in the MH/DD/SA Extended Benefit package

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Utilization Management

Referral and Authorization by Local Management Entity is required. An initial 3 hours of assessment is allowable. Additional hours of assessment require authorization.

Entrance Criteria

The recipient is eligible for this service when:

A There is a known or suspected mental health or substance abuse diagnosis

OR

B Initial screening/triage information indicates a need for additional mental health/substance abuse treatment

AND

C Recipient meets the Division's eligibility criteria for the Extended Benefit package.

Continued Stay Criteria

NA

Discharge Criteria

NA

Expected Outcomes

A Diagnostic/Assessment determines whether the consumer is appropriate for and can benefit from MH/DD/SA services based upon the consumer's diagnosis, presenting problems, and treatment/recovery goals. It also evaluates the consumer's level of readiness and motivation to engage in treatment. Results from a Diagnostic/Assessment include an interpretation of the assessment information, appropriate case formulation and the development of person centered plan. For substance abusers, a Diagnostic/Assessment recommends a level of placement using NC Modified A/ASAM criteria.

Documentation Requirements

Minimum standard is a note in the consumer's record which includes the purpose of the session and the results of the evaluation, as well as a Diagnostic/Assessment Report at the conclusion of each completed, full Assessment.

Service Exclusions/Limitations

Diagnostic/Assessment is billed for only the initial assessment. Billing for Diagnostic/Assessment will be limited to X units. If prior approval is received from the LME, additional units of Diagnostic/Assessment may be allowable for special evaluations. Diagnostic/Assessment shall not be billed on the same day as Assertive Community Treatment, Intensive In-Home, Multisystemic Therapy, or Community Support Team.

Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

INTENSIVE IN-HOME SERVICES

Service Definition and Required Components

This is a time limited intensive family preservation intervention intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified youth. These services are delivered primarily to children in their family's home with a family focus to:

1. Diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
2. Ensure the linkage to needed community services and resources;
3. Provide self help and living skills training for youth;
4. Provide parenting skills training to help the family build skills for coping with the youth's disorder;
5. Monitor and manage the presenting psychiatric and addiction symptoms; and
6. Work with caregivers in the implementation of home-based behavioral supports. Services may include crisis management, intensive case management, individual and/or family therapy, substance abuse intervention, skills training, and other rehabilitative supports to prevent the need for a out of home, more restrictive services.

This service is a team approach designed to address the identified needs of children and adolescents who are transitioning from out of home placements or are at risk of out of home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24) hours a day by staff that will maintain contact and intervene as one organizational unit.

Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are generally more intensive at the beginning of treatment and decrease over time as the youth and family's coping skills develop.

This team approach is structured face–to–face therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc.

Provider Requirements

Intensive In-Home services must be delivered by practitioners employed by a mental health/substance abuse provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrated that they meet these standards by either being certified by the Local Management Entity or by being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Intensive In-Home providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, street locations, etc.

Organizations that provide Intensive In-Home services must have an on-call capability that can direct consumers to appropriate crisis intervention services.

Staffing Requirements

This service model includes both a Qualified Professional and a minimum of two (2) Paraprofessionals. The Qualified Professional is the team leader who is responsible for coordinating the initial assessment and

developing the youth's Person Centered Plan (PCP). The QP is also responsible for providing or coordinating (with another QP) treatment for the youth or other family members. All treatment must be directed toward the eligible recipient of in-home services. The Paraprofessional staff must work under close supervision of the team leader and provide support services to the youth and family. Team to family ratio shall not exceed one to eight (1 to 8) for each three person team. For Intensive In-Home services focused on substance abuse intervention the team must include a CCS, CCAS, and CSAC.

Service Type/Setting

Intensive In-Home services are direct and indirect periodic services where the team provides direct intervention and also arranges, coordinators, and monitors services on behalf of the recipient. This service is provided in any location. Intensive In-Home services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. Intensive In-Home services also include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan. This service is billable to Medicaid.

Clinical Requirements

For Intensive In-Home recipients, a minimum of twelve (12) contacts must occur within the first month, with 50% of the units occurring face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts.

Sixty Per Cent (60%) or more of these non face-to-face units must be spent working outside of the agency's facility, with or on behalf of consumers. The portion of services will be measured in total units over those which were provided during the timeframes set forth in the plan. Units will be billed in fifteen (15) minute increments. For the second and third months of Intensive In-Home services, an average of six (6) contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

Utilization Management

Referral and Authorization by Local Management Entity is required. Service must be included in an individual's Person-Centered Plan. Initial authorization for services would not exceed a three (3) month period. A maximum of thirty-two (32) units of intensive in home services can be provided in a twenty-four (24) hour period. No more than 360 units of services can be provided to an individual in a three (3) month period.

Entrance Criteria

A recipient is eligible for this service when:

A. There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability

AND,

B. Treatment in a less restrictive setting was attempted or evaluated during the assessment but was found to be inappropriate or not effective;

AND,

C. The youth and/or family have insufficient or severely limited resources or skills necessary to cope with an immediate crisis.

AND

D. The youth and/or family issues are unmanageable in school based on behavioral program settings and require intensive coordinated clinical and positive behavioral interventions;

AND

E. The youth is at risk of out of home placement or is currently in an out of home placement and reunification is imminent.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the youth's service plan or the youth continues to be at risk for out-of-home placement:

A. Recipient has achieved initial service plan goals and additional goals are indicated.

AND

B. Recipient is making satisfactory progress toward meeting goals.

AND

C. Recipient is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

OR

D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

OR

E. Recipient is regressing; the service plan must be modified to identify more effective interventions.

Utilization Management

Utilization Review must be conducted every three (3) months and is so documented in the service record.

Discharge Criteria

Service recipient's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A Recipient has achieved goals; discharge to a lower level of care is indicated, or recipient has entered a structured SA treatment program.

OR

B The youth and families/caregivers have skills and resources needed to step down to a less intensive service;

AND

C There is a significant reduction in the youth's problem behavior and/or increase in pro-social behaviors;

AND

D The youth's requests discharge (and is not imminently dangerous to self or others);

AND

E An adequate continuing care plan has been established.

Documentation Requirements

Minimum standard is a daily full service note that includes the purpose of contact, describes the provider's interventions; the time spent performing the intervention and the effectiveness of the interventions.

Service Exclusions

An individual can receive Intensive In-Home services from only one (1) provider at a time.

Intensive In-Home can be billed for individuals receiving Intensive In-Home, Community Support or living in other residential facilities for a limited period of time to ensure successful transition from the residential setting. Assertive Community Treatment, Multisystemic Therapy, Partial Hospitalization, Day Treatment, Hourly Respite, individual, group or family therapy cannot be billed while an individual is receiving Intensive In-Home Services. Community Support Services may be billed for an individual receiving Intensive In Home Services for a two-

week transition period. Intensive In-Home services cannot be billed when the individual is receiving services in a structured SA treatment program.

Intensive In-Home and residential services can be billed for a maximum of two (2) consecutive weeks per each admission or discharge from a residential facility.

Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

MULTISYSTEMIC THERAPY (MST)

Service Definition and Required Components

MST is a program designed to enhance the skills of youth ages 7-18 and their families who have anti-social, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency; are adjudicated youth returning from out-of-home placement; are chronic or violent juvenile offenders, and/or are youth with serious emotional disturbances involved in the juvenile justice system. MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention, individual therapeutic interventions with the youth and family, peer intervention, case management, crisis stabilization, and respite. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. Services are available in-home, at school and in other community settings. The duration of MST intervention is three (3) to five (5) months. MST involves families and other systems such as the school, probation officers, extended families and community connections.

This service is a team approach designed to address the identified needs of children and adolescents with significant behavioral problems and who are transitioning from out of home placements or are at risk of out of home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24) hours a day by staff that will maintain contact and intervene as one organizational unit.

This team approach is structured face–to–face therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. The service promotes the family's capacity to monitor and manage the youth's behavior.

Provider Requirements

Multisystemic therapy services must be delivered by practitioners employed by a mental health/substance abuse provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrated that they meet these standards by either being certified by the Local Management Entity or by being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Multisystemic therapy providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, street locations, etc.

Organizations that provide Multisystemic Therapy services must have an on-call capability that can direct consumers to appropriate crisis intervention services.

Staffing Requirements

This service model includes at a minimum a master's level Qualified Professional who is the team supervisor and three (3) Qualified Professionals staff who provides available 24-hour coverage. Staff are required to participate in MST introductory training and quarterly training on topics directly related to the needs of MST youth and their family on an ongoing basis. All staff on the MST team shall receive a minimum of one (1) hour of group

supervision and one (1) hour of telephone consultation per week. MST team to family ratio shall not exceed one to five (1:5) for each four (4) person team.

Service Type/Setting

MST is a direct and indirect periodic service where the MST worker provides direct intervention and also arranges, coordinators, and monitors services on behalf of the recipient. This service is provided in any location. MST services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. MST also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan. This service is billable to Medicaid.

Clinical Requirements

For registered recipients, a minimum of twelve (12) contacts must occur within the first month, with 50% of the contacts occurring face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts.

Sixty Per Cent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers. The portion of services will be measured in total units over those which were provided during the timeframes set forth in the plan. Units will be billed in fifteen (15) minute increments. For the second and third months of MST an average of six (6) contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

Utilization Management

Referral and Authorization by Local Management Entity is required. For Medicaid reimbursement, the service must be included in an individual's Person Centered Plan. Initial authorization for services must not exceed a three (3) month period. A maximum of thirty-two (32) units of MST services can be provided in a twenty-four (24) hour period. No more than 480 units of services can be provided to an individual in a three (3) month period. MST services must be reviewed for continued stay every ninety (90) days.

Entrance Criteria

A There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability.

AND

B The youth must be between the ages of 7-18;

AND

C The youth displays willing misconduct behaviors (e.g. theft, property destruction, assault, truancy; as well as substance use/abuse or juvenile sex offense, when in conjunction with other delinquent behaviors);

AND

D The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent within 30 days of referral;

AND

E The youth has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the youth's service plan or the youth continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Youth continues to exhibit willful misconduct behaviors;

AND

B. There is a reasonable expectation that the youth will continue to make progress in reaching overarching goals identified in MST in the first four (4) weeks.

OR

C. Youth is not making progress; the service plan must be modified to identify more effective interventions.

OR

D. Youth is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria

Youth's level of functioning has improved with respect to the goals outlined in the service plan, or no longer benefits from this service. The decision should be based on one of the following:

A Youth has achieved Seventy-Five Per Cent (75%) of the service plan goals, discharge to a lower level of care is indicated;

OR

B Youth is not making progress, or is regressing, and all realistic treatment options within this modality have been exhausted.

OR

The youth/family requests discharge and is not imminently dangerous to self or others

**Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.*

Documentation Requirements

Minimum standard is a daily full service note that includes the purpose of contact, describes the provider's interventions; the time spent performing the intervention and the effectiveness of the interventions.

Service Exclusions

An individual can receive MST services from only one provider at a time.

MST can be billed for individuals receiving Community Support or living in other residential facilities for a limited period of time to ensure successful transition from the residential setting. Assertive Community Treatment, Intensive In-Home Services, Partial Hospitalization, Day Treatment, Hourly Respite, individual, group or family therapy cannot be billed while an individual is receiving MST. Community Support services may be billed for an individual receiving MST Services for a two (2) week transition period. MST and residential services can be billed for a maximum of two (2) consecutive weeks per each admission or discharge from a residential facility.

Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

COMMUNITY SUPPORT TEAM (CST)

Service Definition and Required Components

Community Support Team (CST) services consist of mental health and substance abuse rehabilitation services and supports necessary to assist adults (age 18 and older) in achieving rehabilitative and recovery goals. This is an intensive community rehabilitation service that provides treatment and restorative interventions to: assist individuals to gain access to necessary services; reduce psychiatric and addiction symptoms and develop optimal community living skills. Services offered by the Community Support teams shall be documented in a Person Centered Plan (PCP) and must include: assistance and support for the individuals in crisis situations; service coordination; psycho-education and support for individuals and their families; individual restorative interventions for the development of interpersonal, community coping and independent living skills; development of symptom monitoring and management skills: monitoring medication and self medication.

Individuals will experience decreased crisis episodes, and increased community tenure, time working, in school or with social contacts, and personal satisfaction and independence. Through supports based on the individuals' needs, consumers will reside in independent or semi-independent living arrangements, and be engaged in the recovery process.

The Community Support Team must consult with identified providers, include their input into the service planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. The provider assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

Provider Requirements

Community Support services provided by a team must be delivered by practitioners employed by a mental health/substance abuse provider organization which meets standards established by the Division of MHDDSAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrated that they meet these standards by either being certified by the Local Management Entity or by being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Community Support Teams must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, street locations, etc.

Organizations that provide team-based Community Support must have a 24/7 on-call capability that can direct consumers to appropriate crisis intervention services.

Staffing Requirements

Persons who meet the requirements specified for Qualified Professional or Associate Professional status according to 10 NCAC may deliver Community Support Team. Supervision is provided according to supervision requirements specified in 10 NCAC 14V and according to licensure requirements of the appropriate discipline.

Paraprofessional level-providers who meet the requirements specified for Paraprofessional status according to 10 NCAC 14V may deliver Community Support Team services within the requirements of the staff definition specific in the above role. Supervision of Paraprofessionals is also to be carried out according to 10 NCAC 14V.

Community Support Teams must be comprised of a minimum of three (3) staff persons meeting the requirements above. Each team must have a team leader who must be either a Qualified Professional or Associate Professional status according to 10 NCAC. It is recommended that the team have at least a .5 FTE team leader that provides clinical and administrative supervisor of the team and also functions as a practicing clinician on the team

The Community Support Team maintains a consumer-to-practitioner ratio of no more than fifteen (15) consumers per staff person. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.

Service Type/Setting

Community Support Team is a direct and indirect periodic service in which the team provides direct intervention and also arranges, coordinators, and monitors services on behalf of the recipient. This service is provided in any location. Community Support Team services are primarily provided in a range of community settings such as recipient's home, homeless shelters, libraries, etc. Community Support Team also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. This service is billable to Medicaid.

Clinical Requirements

For registered recipients, a minimum of eight (8) face-to-face contacts must occur within the first month, with 60% of the contacts occurring face-to-face with the individual.

Sixty Per Cent (60%) or more of CST services that are delivered are performed face-to-face with recipients, and Ninety Per Cent (90%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers.

Utilization Management

Referral and Authorization by Local Management Entity is required. For Medicaid reimbursement, the service must be included in an individual's Person Centered Plan and a Qualified Professional or an Associate Professional must complete service orders on the day the services are provided. Initial authorization for services would not exceed a three (3) month period. A maximum of Y units of CST services can be provided in a 24-hour period. No more than X units of services can be provided to an individual in a three (3) month period.

Entrance Criteria

The recipient is eligible for this service when:

A There are two (2) identified needs in the appropriate documented domains,

AND

B There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability

AND/OR

C Level of Care Criteria, level A/ASAM (American Society for Addiction Medicine

AND

D And four or more of the following conditions:

1. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., two or more admissions per year) or extended hospital stay (30 days within the past year) or psychiatric emergency services.
2. History of inadequate follow-through with elements of a Treatment Plan related to risk factors (including lack of follow through taking medications, following a crisis plan or maintaining housing).

3. Intermittently medication refractory.
4. Co-diagnosis of substance abuse (ASAM – any level of care).
5. Legal issues (conditional release for non-violent offense; history of failures to show in court).
6. Homeless or at high risk of homelessness due to residential instability.
7. Clinical evidence for suicidal gestures and/or ideation in past 3 months.
8. Ongoing inappropriate public behavior in the community within the last three months.
9. Self-harm or threats of harm to others within last year.
10. Evidenced of significant complications such as cognitive impairment, behavioral problems, or medical conditions.
11. A lower level of care has been tried or considered and found inappropriate at this time.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A Recipient has achieved initial service plan goals and additional goals are indicated.
B Recipient is making satisfactory progress toward meeting goals.
C Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D Recipient is not making progress; the service plan must be modified to identify more effective interventions.
E Recipient is regressing; the service plan must be modified to identify more effective interventions.

Utilization review must be conducted every 180 days and is so documented in the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:
A Recipient has achieved goals and is no longer eligible for Community Support Team services.
B Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
C Recipient/family no longer wants Community Support Team services.

**Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.*

Documentation Requirements

Minimum standard is a daily full service note that includes the purpose of contact, describes the provider's interventions; the time spent performing the intervention and the effectiveness of the interventions.

Service Exclusions

An individual can receive Community Support Team services from only one provider at a time.

Community Support Team services can be billed for individuals living in other residential facilities in which they are receiving 'watchful oversight', e.g. supported housing. For persons residing in higher level residential programs (e.g. PRTF, Group Living Moderate and High), Community Support Team services are limited to X hours per Y period of time. Community Support Team services may be provided for a maximum of two (2) weeks to individuals receiving ACT, MST or Intensive In-Home services or structured SA treatment services for

transitional purposes only. Community Support Team and residential services can be billed for a maximum of two (2) consecutive weeks per each admission or discharge from a residential facility.

Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

ASSERTIVE COMMUNITY TREATMENT TEAM (ACTT)

Service Definition and Required Components

The Assertive Community Treatment Team is a service provided by an interdisciplinary team that ensures service availability 24 hours a day and is prepared to carry out a full range of treatment functions wherever and whenever needed. A service recipient is referred to the Assertive Community Treatment Team service when it has been determined that his/her needs are so pervasive and/or unpredictable that they can not be met effectively by any other combination of available community services. Typically this service should be targeted to the 10% of MH/DD/SA service recipients who have serious and persistent mental illness or co-occurring disorders, dual and triply diagnosed and the most complex and expensive treatment needs. The service objectives are addressed by activities designed to: promote symptom stability and appropriate use of medication; restore personal, community living and social skills; promote and maintain physical health; establish access to entitlements, housing, work and social opportunities; and promote and maintain the highest possible level of functioning in the community.

This service is a team approach designed to address the identified needs of specialized populations and/or the long term support of those with persistent MH/DD/SA issues that require intensive interventions to remain stable in the community. These service recipients would tend to be high cost, receive multiple services, decompensate to the point of requiring hospitalization before seeking treatment, seek treatment only during a crisis, or unable to benefit from traditional forms of clinic based services. This population has access to a variety of interventions twenty four (24) hours a day by staff who will maintain contact and intervene as one organizational unit.

This team approach is structured face-to-face scheduled therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, personal care, domestic, psychosocial, problem solving, etc. in preventing, overcoming, or managing the recipient's level of functioning and enhancing his/her ability to remain in the community.

This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength based and focused on promoting symptom stability, increasing the recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

ACTT provides ongoing assertive outreach treatment that is available in order to address the service recipient's needs effectively. Consideration of geographical locale may impact on the effectiveness of this service model. This model is primary a mobile unit, but includes some clinic based services, most often MD visits.

Provider Requirements

Team Composition. The team shall be multidisciplinary and have strong clinical skills in order to carry out the varied activities needed to meet the complex needs of clients and shall include:

Large Team: Maximum serving 100 individuals (ratio of staff to client 1-10 up to 75 clients, then ratio of staff to client 1 - 8)

A. Psychiatrist - 16 hrs per week, per 50 clients.
B. One FTE Program Assistant.
C. Minimum 10 – 12 FTE clinical staff to include:
    1. One Team Leader, Master's Level, Qualified Mental Health Professional.
    2. 3 FTE Registered Nurse.

3. Four to six Mental Health Professionals qualified to provide clinical and rehabilitation services (specialties - certified SA counselors, VOC specialist, and licensed social worker). Note: at least half of Mental Health Professionals shall be Master's Level.
4. One Paraprofessional staff to provide services to support activities of daily living.
5. One Peer Specialist who is or has been a recipient of mental health services.

Small Team: Serving maximum of 48 individuals (ratio staff to client 1 - 8)

A. Psychiatrist - 16 hours per week.
B. .5 FTE Program Assistance
C. Minimum 6 FTE clinical staff to include:
   1. One Team Leader, Master's Level, Qualified Mental Health Professional.
   2. Two Registered Nurses.
   3. Two Mental Health Professionals qualified to provide clinical and rehabilitation services (specialties, certified substance abuse counselor, vocational specialist, and licensed social workers). Note: at least one Mental Health Professional shall be Master's Level.
   4. One Peer Specialist who is or has been a recipient of mental health services.

Staffing Requirements

Available 24 hours per day.

Hours of operation.

Large Team: Two 8 hour shifts: maximum 12 hours weekdays.
One 8 hour shift: each weekday and all holidays.

Small Team: One 8 hour shift weekdays, scheduled evenings.

Service Type/Setting

ACTT is a combination day/night and periodic service model that offers service availability 24 hours a day. The ACTT staff is on-call and makes face to face visits with recipients during crisis. There is a separate number for recipients of ACTT to call during crisis. (If a central number is used then they only serve a linkage role and they link everyone – they do not triage; this is done by ACTT. Payment Unit is client month based on at least eight documented face to face contacts on different days with client during the month. The team should be clinical and multidisciplinary in order to carry out the varied activities needed to meet the complex needs of the clients. The types of activities that this team would provide include those typical of Evaluation, Outpatient Treatment, Case Management Community-Based Services Emergency/Crisis Services, Substance Abuse Service, and Vocational Rehabilitation Services.

This service is provided face-to-face in any location outside the clinical setting.

Clinical Requirements

Minimum of eight (8) face-to-face contacts on different days per month.

Utilization Management

Utilization review must be conducted every twelve (12) months and is so documented in the service record.

Admission Criteria

Individuals with significant functional impairments as demonstrated by at least one of the following conditions:

A. Inability to consistently perform the range of practical daily living tasks required for basic functioning in the community (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal business

affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions) or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

B. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities).
C. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

AND

D. Individuals with one or more of the following problems, which are indicators of continuous high-service needs (I. e., greater than eight hours per month):
   1. High use of acute psychiatric hospitals (e.g. two or more admissions per year) or psychiatric emergency services.
   2. Intractable (i.e., persistent or very recurrent), severe major symptoms (e.g., affective, psychotic, suicidal).
   3. Coexisting substance use disorder of significant duration (e.g., greater than six months).
   4. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
   5. Inability to meet basic survival needs or residing in substandard housing, homeless, or imminent risk of becoming homeless.
   6. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
   7. Inability to participate in traditional office-based services.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on attempts to reduce ACTT services in a planful way or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.
E. Recipient is regressing; the service plan must be modified to identify more effective interventions.

If the recipient is functioning effectively with this service and discharge would otherwise be indicated, ACTT services should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

A. Past history of regression in the absence of ACTT is documented in the service record or attempts to titrate ACTT downward have resulted in regression,

OR

B. In the event there is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains, the presence of a DSM IV diagnosis would necessitate a disability management approach.

Discharge Criteria

Discharges from the ACTT team occur when individuals and program staff mutually agree to the termination of services. This shall occur when individuals.

A. Move outside the geographic area of ACTT's responsibility. In such cases, the ACTT team shall arrange for transfer of mental health service responsibility to a provider wherever the client is moving. Preferably,

another ACT Team. The ACTT team shall maintain contact with the client until this service transfer is arranged.

B. Demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without requiring assistance from the program, as evidenced by an average of eight face-to-face contacts per month during any three consecutive month.
C. Request discharge, despite the team's best efforts to develop a treatment plan acceptable to them.

**Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.*

Documentation Requirements

Service orders must be completed by a physician or licensed psychologist, prior to or on the day services are to be provided.

Minimum documentation is a service note on a monthly basis that includes the purpose of contact, describes the provider's interventions, and the effectiveness of the interventions. Services may be billed when provided 30 days prior to discharge when a recipient resides in a general hospital or psychiatric in patient setting and retains Medicaid eligibility.

Service Exclusions

May not bill for any other periodic services.
May not bill for any month when less than nine (9) face-to-face contacts on different days.
May not bill when client is in a nursing home, hospital, Residential level II-IV, or PSR.

Appropriate Service Codes				
Medicaid	**IPRS**	**Pioneer**	**UCR-WM (CTSP)**	**UCR-TS (MR/MI)**
Y2313	**Y2313**	**680**	**N/A**	**680**